

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10685

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10679

1. PLACE OF DEATH a. COUNTY <u>Taibot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>10 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>17X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Tilghman</u> Last <u>Bishop</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15-1873</u>
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	
11. BIRTH PLACE (State or foreign country) <u>Pennichell QACs Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Frances A Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-3449408</u>	
17. INFORMANT <u>Sehel M Bishop</u>		Address <u>Queenstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>old myocardial infarct</u> DUE TO (c) <u>Carcinoma of tonsil</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent TUR for Prostatic hypertrophy &amp; hemorrhage</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>September 15, 19</u> , and that death occurred on <u>Sept 30</u> at <u>1:30</u> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>30 Sept 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. C. H. Schmidt</u>		22d. ADDRESS <u>Easton Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 3-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cheslerfield</u>		23d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baring</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>of Baring Bros, Centerville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>OCT 5 '61</u>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
10680											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>29</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Sally</u> Middle <u>Blackston</u> Last <u>Blackston</u>						4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-83</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Blackston</u>						14. MOTHER'S MAIDEN NAME <u>Alexzene Blackston</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Annie Jackson</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED <u>9-6-61</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>Sept. 5, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		22d. LOCATION (City, town, or county) <u>Easton</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR <u>James R. Ashfield</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>Sept 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

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STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1901  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1899  
AND  
A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1900  
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.  
1901.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON.</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Caruthers</b> Last <b>Bower Lind</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26, 1891</b>	
9. AGE (In years last birthday) <b>69</b> yrs		IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>12</b> Min.		IF UNDER 24 HRS. Months <b>6</b> Days <b>12</b> Hours <b>12</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>New York City, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dave Hennen Caruthers</b>				14. MOTHER'S MAIDEN NAME <b>Mary Melville</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>ukn</b>		17. INFORMANT <b>Mrs. G. Hilmer Lundbeck, New York 20, N.Y.</b>			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150X Cerebral anoxia</b> DUE TO <b>radical obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Recurrent Circumstances of asphyxias</b> (b) <b>(?)</b> (c) <b>3 mos</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1950</b> to <b>12 Sept 1961</b> , that (I) (we) last saw the deceased alive on <b>12 Sept 1961</b> , and that death occurred at <b>12:01 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Thorston Harrison</b>				22b. DATE SIGNED <b>13 Sept 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>THORSTON HARRISON</b>				22d. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 14, '61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Frankton Groll</b>				25a. REC'D BY REGISTRAR <b>SEP 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hawk</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

106882

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN lb. <u>1 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Speer</u> Last <u>Brooks</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1918</u>		9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Capitola Wheeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-0394</u>		17. INFORMANT <u>Howard Hudson</u>		Address <u>634 Howard St. Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>1 year</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1950</u> to <u>Sept. 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 3, 1961</u> , and that death occurred at <u>9a.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>S. KRECH JR.</u>				22b. ADDRESS <u>EASTON, Md.</u>		22c. PHYSICIAN'S NAME (Type) <u>S. KRECH JR.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 11, 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Thomas</u>				25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10689 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, it may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, indicate nature of admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON Rural</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Trappe</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith M. Camper</u>		4. DATE OF DEATH Month Day Year <u>Sept. 20, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1902</u>
9. AGE (in years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>59</u>	
11. IF UNDER 24 HRS. Hours Min. <u>59</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Summers</u>		14. MOTHER'S MAIDEN NAME <u>Edith Cole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give branch and service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-28-3749</u>	
17. INFORMANT <u>Mr. Edith Cole</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERFORATING WOUND OF HEART</u> DUE TO <u>816X</u> AUTO ACCIDENT Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>PASSENGER IN CAR INVOLVED IN TWO CAR COLLISION</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-20-61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ROAD</u>	20f. (City or town) (County) (State) <u>NR EASTON TALBOT MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. Welty</u>		DATE SIGNED <u>9-21-61</u>	
EXAMINER'S NAME (Type) <u>WELTY</u>		Address (Street, city, town, or county) <u>Trappe, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-21-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trappe Cemetery</u>	22d. LOCATION (City, town, or country) (State) <u>Trappe, Md.</u>
23. FUNERAL DIRECTOR <u>James B. Radcliff - Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

10882 MEDICAL EXAMINER - CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10690

11866

1. PLACE OF DEATH a. COUNTY <b>TAIBOT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY IN 1b <b>2 1/2 hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> d. STREET ADDRESS <b>1128 W. Aurora St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Barbara Jean CONAWAY</b> First Middle Last 5 SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>9-22-61</b> 9. AGE (In years lost birthday) <b>2</b> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>none</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>none</b> 11. BIRTHPLACE (State or foreign country) <b>Memorial Hospital Eastern, U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		4. DATE OF DEATH Month Day Year <b>9 - 23 1961</b>	
13. FATHER'S NAME <b>HARVEY LOUIS Conaway</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <b>no</b> 16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT <b>HARVEY LOUIS CONAWAY</b> Address <b>1128 W. Aurora St.</b>		14. MOTHER'S MAIDEN NAME <b>Bertie Mae Warner</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) <b>Atelectasis</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 1/2 hrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>9-22-61</b> to <b>9-23-61</b> , that (I) (we) last saw the deceased alive on <b>9-23-1961</b> and that death occurred <b>11:17 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Donald F. Bartley</b> 22c. PHYSICIAN'S NAME (Type) <b>DONALD F. BARTLEY</b>		22b. DATE SIGNED <b>10-2-61</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>EASTON, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Incineration</b> 23b. DATE THEREOF <b>Incineration</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b> 23d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Incineration</b> 25a. REC'D BY REGISTRAR DATE <b>OCT 23 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled out by the funeral director, who the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. STREET ADDRESS <b>Maple Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE BELLE DEAN</b>				4. DATE OF DEATH Month Day Year <b>Sept. 12 1961</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 28, 1884</b>	9 AGE, in years last birthday <b>77</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>William T. Blades</b>				14 MOTHER'S MAIDEN NAME <b>Alice Dukes</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>		17 INFORMANT Address <b>Hayward W. Dean, Preston, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Bacteremic Shock.</b> 609X DUE TO (b) <b>Generalized Septicemia</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Acute Urinary Tract Infection</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>6 days</b> <b>8 wks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis &amp; Heart Disease. Fracture of Right Femur</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in yard next to her home</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>7/27 1961</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Preston Caroline Md.</b>	
21 I certify that (I) (this hospital) attended the deceased from <b>May 20 1961</b> to <b>9/12 1961</b> , that (I) (we) last saw the deceased alive on <b>9/11 1961</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Harold B. Plummer</b>				22b. DATE <b>9/13/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Harold B. Plummer</b>				22d. ADDRESS <b>Preston Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 15, '61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Church</b>		23d. LOCAT ON (City, town, or county) (State) <b>Preston, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. M. Hall</b>				ADDRESS <b>PRESTON, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 15 61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Clara S. Plummer</b>			

10684

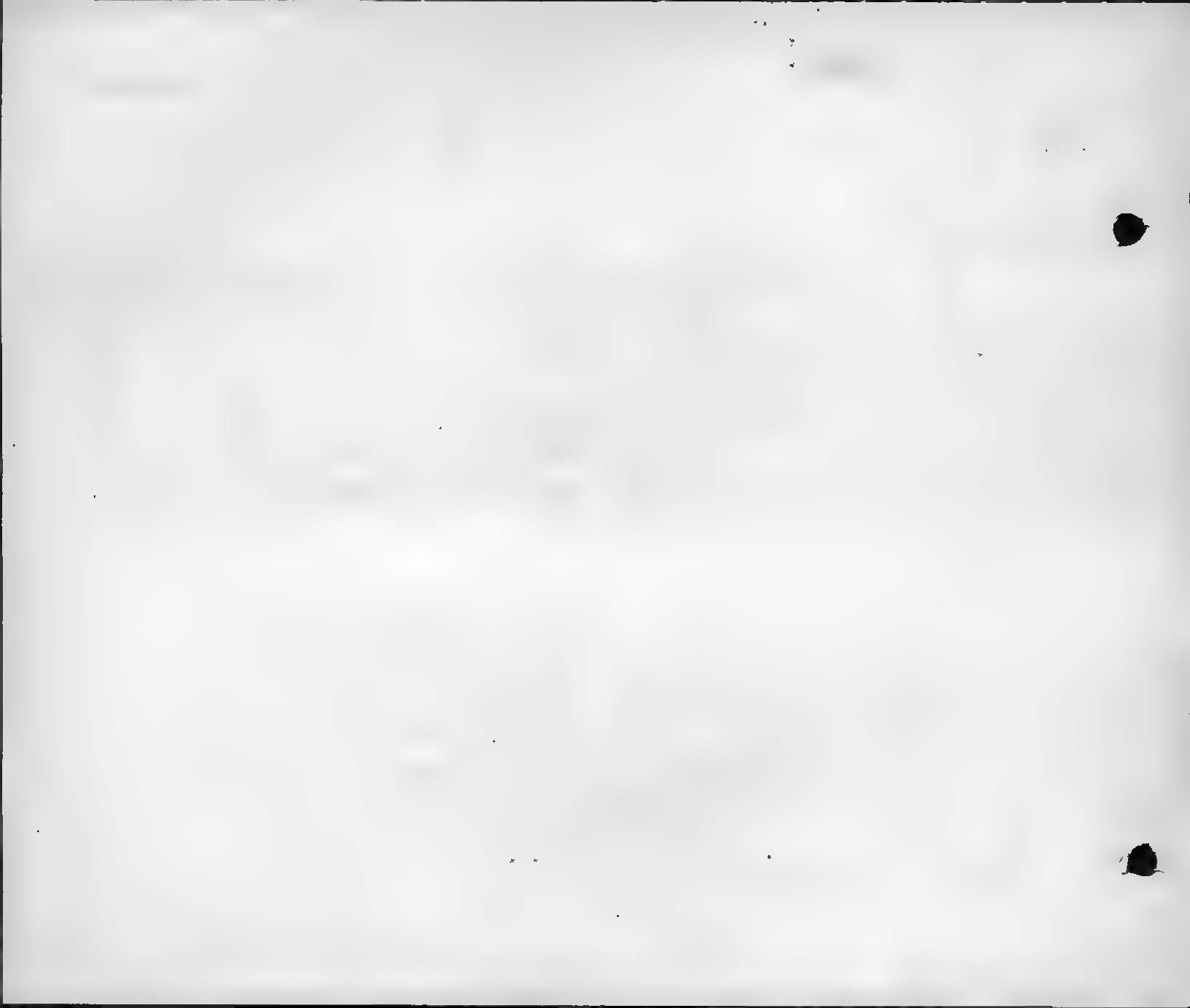




10692

10685

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res. given, enter admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marion F. Everett</u>		4. DATE OF DEATH <u>September 21 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AMOS EVERETT</u>		14. MOTHER'S MAIDEN NAME <u>VICTORIA HAWKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-9740</u>	
17. INFORMANT <u>GILL EVERETT</u>		Address <u>CHURCH HILL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute aortic stenosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>420.0</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY: Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>9-10-1961</u> to <u>9-20-1961</u> that (I) (we) last saw the deceased alive on <u>9-20-1961</u> and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald F. Bartley</u> M.D.		22b. DATE SIGNED <u>9-21-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald F. Bartley</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept 23-1961</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>church Hill</u>	23d. LOCATION (City, town, or county) (State) <u>church Hill MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		25a. REC'D BY REGISTRAR <u>SEP 27 '61</u>	
ADDRESS <u>church Hill</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

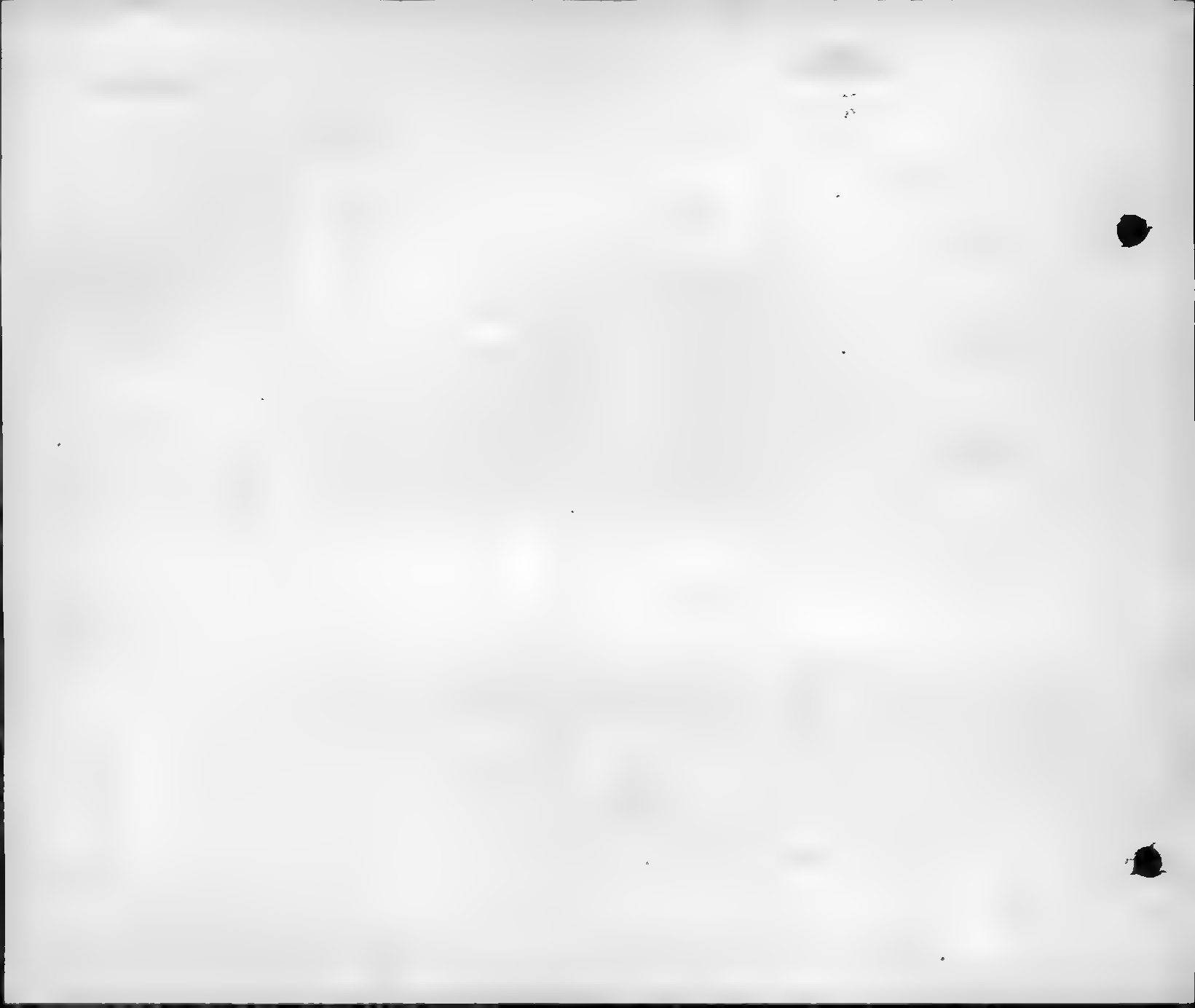
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10693  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Res. Sec. or Institution) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairbank</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tilghman's Island</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Frank</b> Last <b>Fairbank</b>				4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1876</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Fairbank</b>				14. MOTHER'S MAIDEN NAME <b>Francis Harrison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-34-3120</b>		17. INFORMANT Address <b>Mrs. Florence A. Fairbank, Tilghman, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Coronary Artery Disease</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Serility</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7/12</b> <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. <b>19</b> Day. <b>19</b> Hour <b>a. m.</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19 61 to Sept 22 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept 22 1961</b> , and that death occurred at <b>9:28 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Guy M. Reeser, Sr., M.D.</b>				22b. DATE SIGNED <b>SEP 26 1961</b>		22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Guy Reeser, Sr., M.D.</b>				22d. ADDRESS <b>Tilghman, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairbank Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Tilghman, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Leeds Moore</b>				25a. REC'D BY REGISTRAR <b>SEP 26 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

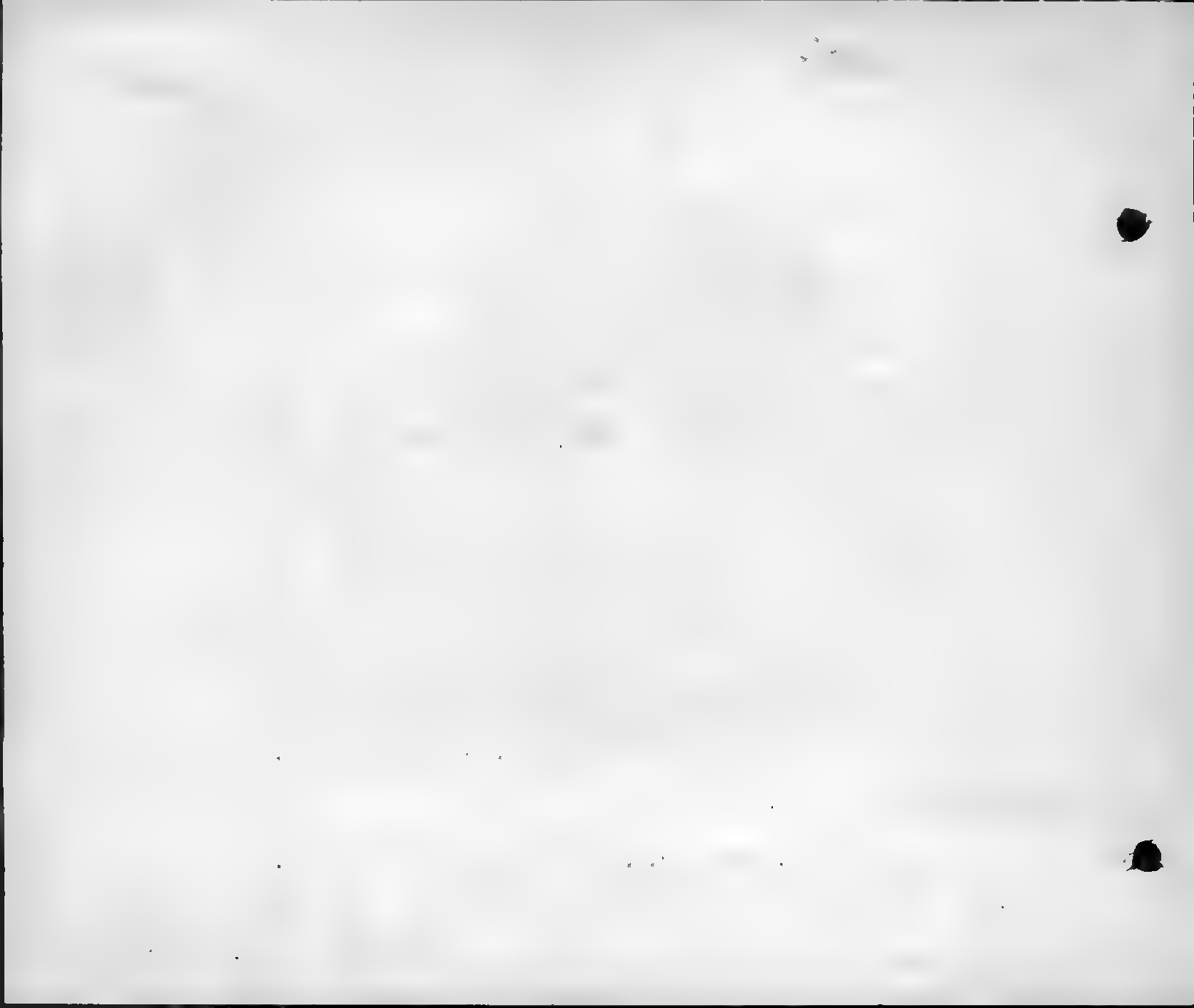
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1 PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Res. date of admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>39 min.</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>PARRON</b> First <b>GANNON</b> Last				4. DATE OF DEATH <b>Sept 14 1961</b> Month <b>Sept</b> Day <b>14</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 5, 1895</b>	
9. AGE (In years last birthday) <b>63</b> yrs		IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b> Hours <b>3</b> Min.		IF UNDER 24 HRS Months <b>6</b> Days <b>3</b> Hours <b>3</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Smelter Supt.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Bowley Gannon</b>				14. MOTHER'S MAIDEN NAME <b>Nord Caroline Lynch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>213-24-076</b>			
17. INFORMANT <b>Mrs. Margaret Sullivan Easton Md</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>410.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO <b>Unknown</b> (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 14, 1961</b> to <b>Sept. 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>2:30 p.m.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Robert W. Trever</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Trever, M.D.</b>				22d. ADDRESS <b>Easton, Maryland.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Sept. 18, 1961</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Spring Hill Cem. Easton</b>		23d. LOCAL (City, town or county) (State) <b>Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Neumann</b>				ADDRESS <b>Easton, Md.</b>		25a. REC'D BY REG. STRAR <b>SEP 20 1961</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





VR A15 (4)  
15M 9/59

VR A15 (4)  
15M 9/59

## 10695

10688

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>34 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		d. STREET ADDRESS <u>203 Daow St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARtha</u> <u>Goldsborough</u>		4. DATE OF DEATH Month Day Year <u>Sept</u> <u>7</u> <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1889</u>
9. AGE (in years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Francis Cunningham Goldsborough</u>		14. MOTHER'S MAIDEN NAME <u>Mary Edith Goldsborough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Richard Goldsborough</u> Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>+ 20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> (c) <u>Arteriosclerotic Coronary Artery Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>33 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3 Aug</u> 19 <u>61</u> to <u>28 Sept</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>28 Sept</u> 19 <u>61</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Thorston Harrison</u>		22b. DATE SIGNED <u>9 Sept 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>		22d. ADDRESS <u>Easton Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried 9/61</u>	23b. DATE THEREOF <u>9/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Goldsborough</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10696  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shaple</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shaple</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Milton Greenwood</u>		4. DATE OF DEATH <u>9</u> <u>9</u> <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Greenwood</u>		14. MOTHER'S MAIDEN NAME <u>Georgia Hyndson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-20-6542</u>	
17. INFORMANT <u>Milton Greenwood</u>		Address <u>Centreville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>2M0-</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 7, 1961</u> to <u>9-9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9-2</u> 19 <u>61</u> , and that death occurred on <u>9-9</u> 19 <u>61</u> at the causes and on the date stated above.			
22a. SIGNATURE <u>William L. Winters</u>		22b. DATE SIGNED <u>9-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>		22d. ADDRESS <u>210 E DOVER, EASTON, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 12, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Easton, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnamason</u>		25a. REC'D BY REGISTRAR <u>SEP 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10697

10690

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>220 S. Washington St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dorothy Burg Hartshorn</b>				4. DATE OF DEATH Month <b>September</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 17, 1894</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>----- Burg</b>				14. MOTHER'S MAIDEN NAME <b>---- unknown -----</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Nicholas R. Hartshorn, Easton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>2</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Arthur B. Cecil, Jr. M.D.</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Arthur B. Cecil, Jr. M.D.</b>	
22d. ADDRESS <b>Easton, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Sept. 5, '61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemt.</b>		23d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Frempton Carroll</b>				25a. REC'D BY REGISTRAR <b>SEP 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. Thos S. Harris</b>	
ADDRESS <b>Easton, Md.</b>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with



**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

10698

10691

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> MARYLAND			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) ✓ a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRICE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hospital</u>			d. STREET ADDRESS <u>—</u>		17X
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Alphonso</u> Last <u>JARRELL</u>			<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>15</u> Year <u>1961</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>COL.</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1881</u>	<b>9. AGE</b> (In years last birthday) <u>abt 80</u>	<b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARM</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>JOHN HENRY JARRELL</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>FAX</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>	<b>16. SOCIAL SECURITY NO</b> <u>218-20-8015</u>	<b>17. INFORMANT</b> <u>Gillian Persons = Price Ind.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic</u> DUE TO (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>(?)</u> <u>121</u>
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4 Sept</u> <u>1961</u> <b>to</b> <u>15 Sept</u> <u>1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>14 Sept</u> <u>1961</u> <b>and that death occurred at</b> <u>10:35 PM</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Thorston Harrison</u>			<b>22b. DATE SIGNED</b> <u>18 Sept 61</u>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>THORSTON HARRISON</u>			<b>22d. ADDRESS</b> <u>Easton Maryland</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>9-18</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Boesville</u>		<b>23d. LOCATION (City, town, or county)</b> <b>(State)</b> <u>near Church Hill Ind.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edgar L. Sam</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>SEP 27 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

the State Board of Health and in any event, within 72 hours after death



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10692

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		c. LENGTH OF STAY IN 1b <u>hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>A.</u> Last <u>Jenkins</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 16, 1896</u>
9. AGE in years <u>65</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Above</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert Smith</u>		14. MOTHER'S MAIDEN NAME <u>Susan Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>207-053856</u>	
17. INFORMANT <u>Charles Jenkins</u>		Address <u>Royal Oak</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>4 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>2 May</u> , 19 <u>60</u> to <u>13 Sept</u> , 19 <u>61</u> , that (1) (we) last saw the deceased alive on <u>19</u> , and that death occurred on <u>13 Sept</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. Lane Wroth</u>		22b. DATE SIGNED <u>SEP 15 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-16-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hammond Union Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Draskieff</u>		25a. REC'D BY REGISTRAR <u>SEP 15 '61</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Hanna</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10693

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY IN 1b <b>1 day</b>		2. USUAL RESIDENCE (Where deceased lived If institution (Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Georgetown</b> d. STREET ADDRESS <b>Evans Ave 17 X</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sadie Elizabeth Johnson</b>		4. DATE OF DEATH <b>Sept 29 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 4 - 1877</b>
9. AGE (In years last birthday) <b>84 yrs</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <b>Nursewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Georgetown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph W. Collins</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Collins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>218-16-7511</b>	
17. INFORMANT <b>Addie E Knight</b>		Address <b>Georgetown, Md</b>	
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>561.2 Intestinal obstruction due to incarcerated umbilical hernia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 week?</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) <b>Arteriosclerosis; A. H. S &amp; Cardiac failure. Pulmonary edema?</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/28/61</b> to <b>9/29</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/29/61</b> 19 <b>61</b> , and that death occurred at <b>12 pm</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. D. Noble</b> M.D.		22b. DATE SIGNED <b>10/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. NOBLE</b>		22d. ADDRESS <b>2 South Hanson Street, Easton, Md</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 2 - 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chateau de la</b>		23d. LOCATION (City, town, or county) (State) <b>Chestertown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Beckley, Jr. Baltimore, Md</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



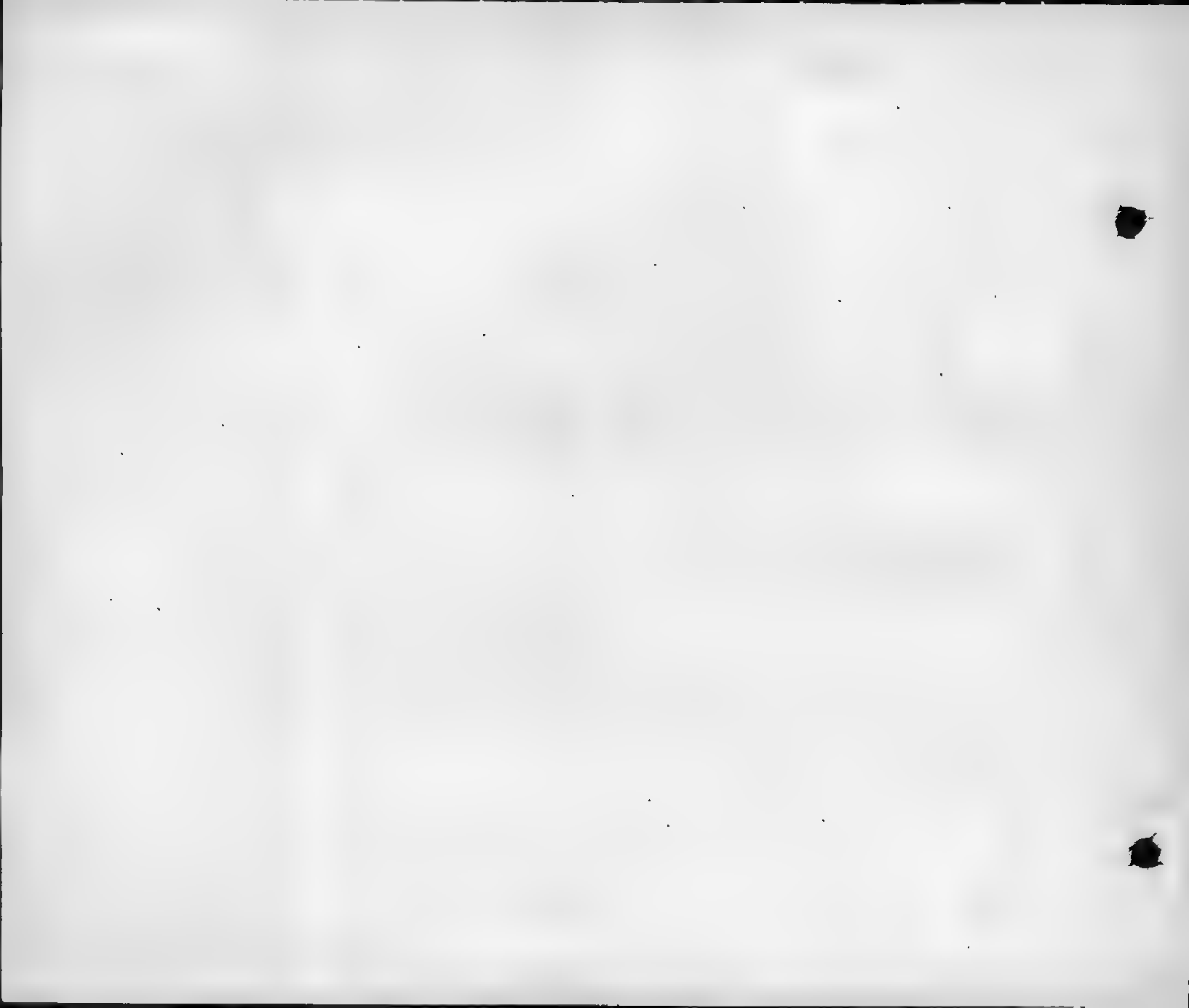


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

10701

10694

1 PLACE OF DEATH a. COUNTY <u>TA/601</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived) If institution: Residence (Residence) <input checked="" type="checkbox"/> a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>42 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital Inc</u>		d. STREET ADDRESS <u>HURLOCK</u>	
3 NAME OF DECEASED (Type or print) <u>YVONNE Decalaria Jones</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 2, 1911</u>
9. AGE (In years last birthday) <u>49</u>		IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gilbert Jones</u>		14. MOTHER'S MAIDEN NAME <u>Norma Jenkins</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Norma Jones</u>		Address <u>Hurlock, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bi-lateral pneumonia</u> <u>763.0</u> DUE TO <u>r</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u>		22b. DATE <u>22 Sept 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 23, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hurlock Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hurlock, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>James B. Daniel, Easton</u>		25a. REC'D BY REGISTRAR <u>SEP 26 '61</u>	
ADDRESS <u>Easton, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10702

10695

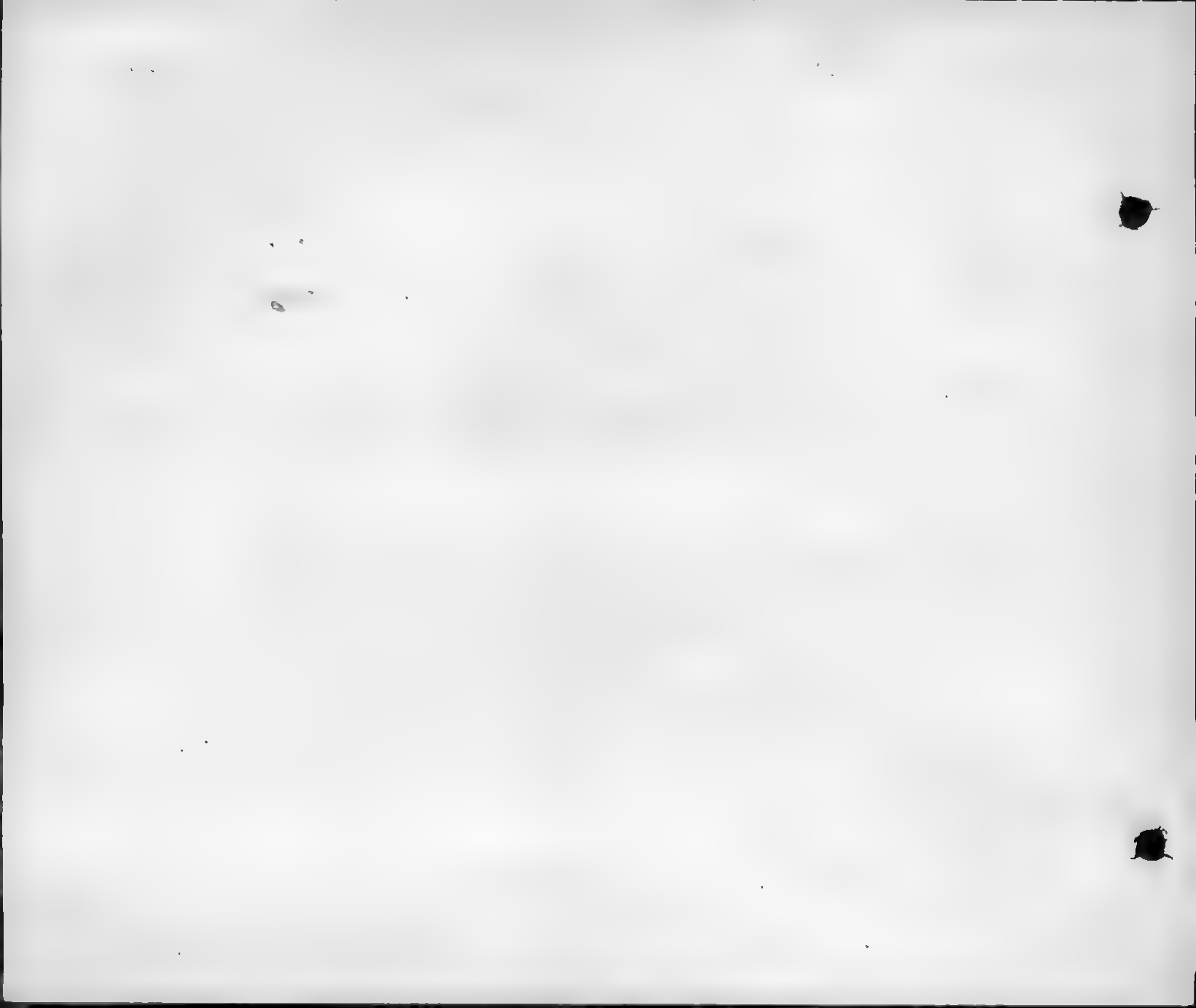
10695

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

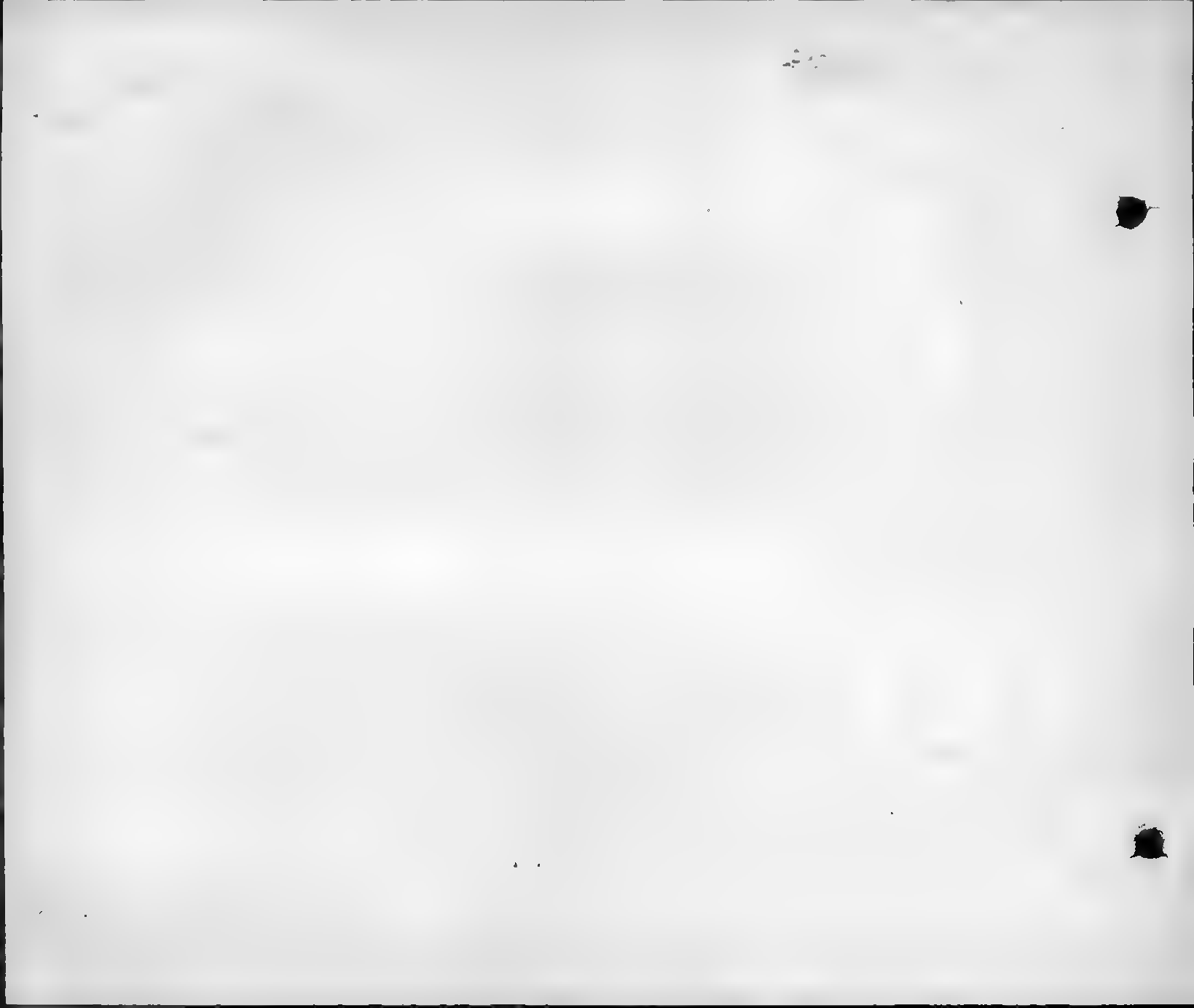
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>20 S. Harrison St.</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia Butler Sedum</u>		4. DATE OF DEATH <u>Sept. 1, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5, 1895</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Butler</u>		14. MOTHER'S MAIDEN NAME <u>Laura Whitby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>William C. Sedum</u> Address <u>Easton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia, left</u> DUE TO <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ulceration, colitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>9/11, 1961</u> (that (I) (we) last saw the deceased alive on <u>9/11, 1961</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>		23b. DATE THEREOF <u>Sept. 4, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u> ADDRESS <u>Easton Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 8 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

10704

**CERTIFICATE OF DEATH**

Item 7 Film G295

9/21/61 1WK

10697

1 PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Lou</b> Last <b>MAKER Mackell</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>13</b> Year <b>1961</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Colored</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9 - 1921</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>System Packer</b>	
11 BIRTHPLACE (State or foreign country) <b>Amberg Na</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Charles Henry Smith</b>		14 MOTHER'S MAIDEN NAME <b>Estelle B. Boyd</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>214-03-5145</b>	
17. INFORMANT <b>Estelle B. Boyd</b> Address <b>Amberg Virginia</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>arterio nephrosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>(?)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subarachnoid hemorrhage</b>		19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>4 Sept</b> 19 <b>61</b> to <b>13 Sept</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>13 Sept</b> 19 <b>61</b> , and that death occurred at <b>10 AM</b> from the causes and on the date stated above			
22a SIGNATURE <b>HURSTON HARRISON</b>		22b DATE SIGNED <b>13 Sept 61</b>	
22c PHYSICIAN'S NAME (Type) <b>HURSTON HARRISON</b>		22d ADDRESS <b>Carlton, Maryland</b>	
23a BURIAL, CREMATION, REINTERMENT (Specify)	23b DATE THEREOF <b>Sept 15 - 1961</b>	23c NAME OF CEMETERY OR CREMATORY <b>Geosmonville Methodist Church</b>	23d LOCATION (City, town, or county) (State) <b>Geosmonville Md.</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>James H. B. [illegible]</b>		25a REC'D BY REGISTRAR <b>SEP 18 '61</b>	
25b REGISTRAR'S SIGNATURE			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10705

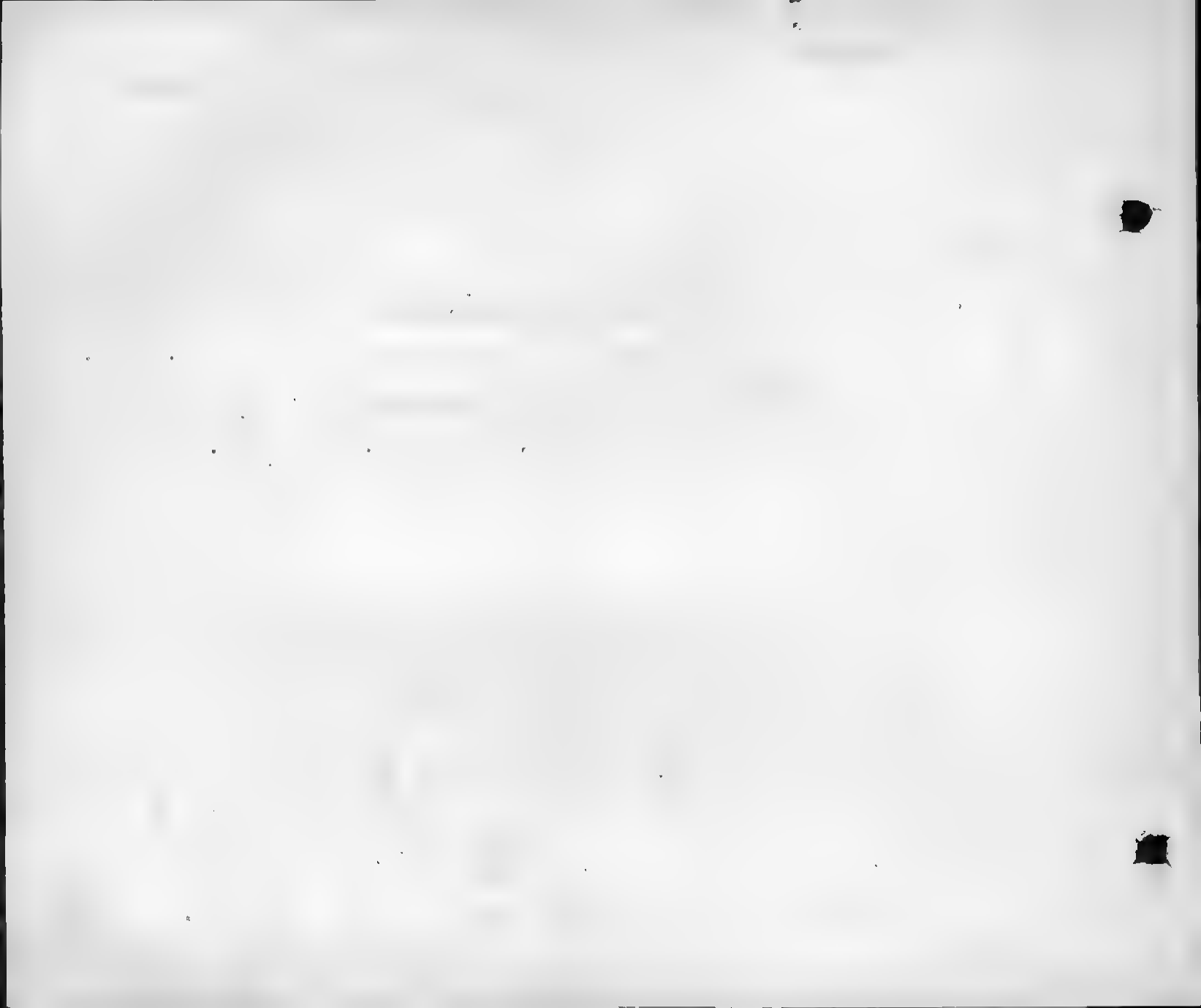
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8, 9 & 14 Filed 10/17/61

10698

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived a. STATE <u>New York</u> b. COUNTY <u>New York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>21 hr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>L.</u> Last <u>Masline</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1961</u>	
5 SEX <u>F.</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1874</u> <u>May 22, 1873</u> 87 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>John Simmen</u> <u>Charles***Masline</u>		14 MOTHER'S MAIDEN NAME <u>Magdeline B. Becker</u> <u>Margreth Becker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Chester M. Smith</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma, Throat &amp; Stomach</u> 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>10 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>E. C. H. Schmidt</u>		22b. DATE SIGNED <u>20 Sept 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 23, 61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Wye Churchyard</u>		23d. LOCATION (City, town, or county) (State) <u>Wye Mills, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edison Md</u>		25a. REC'D BY REGISTRAR <u>SEP 22 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Clarence L. H...</u>			







10707  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

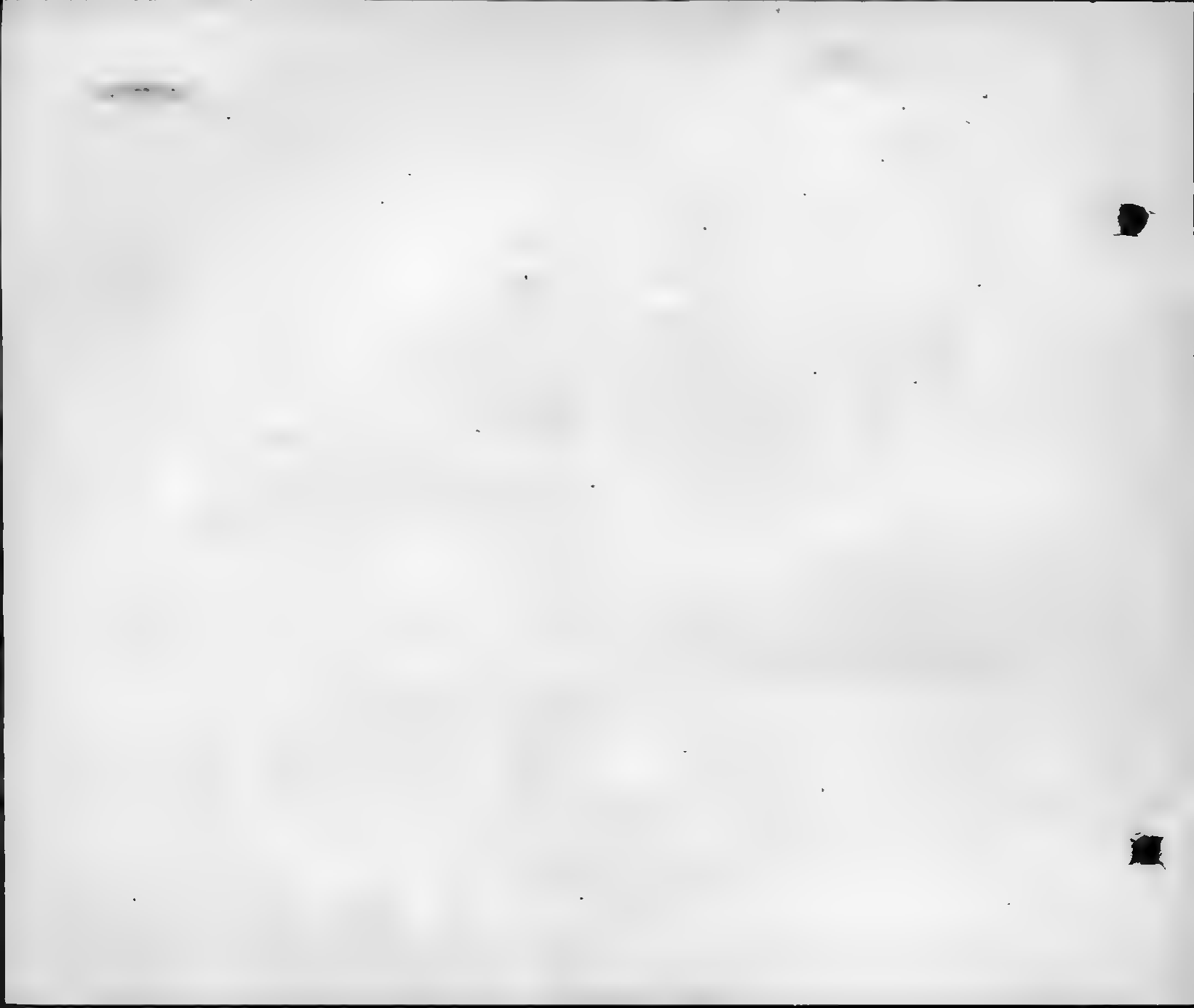
1. PLACE OF DEATH a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salt Lake</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. of Institution) a. STATE <i>Maryland</i> b. COUNTY <i>Salt Lake</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels (Rural)</i>		c. LENGTH OF STAY IN 1b <i>6 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rio Costa Nursing Home</i>		d. STREET ADDRESS <i>307 S. Hanson St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>Hoble</i> Last <i>Murphy</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>30</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 19, 1882</i>
9. AGE (in years last birthday) yrs <i>78</i>		IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i>	IF UNDER 24 HRS Hours <i>1</i> Min <i>1</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Charles E. Noble</i>		14. MOTHER'S MAIDEN NAME <i>Laura Nichols</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mr. Oliver Murphy</i>		Address <i>307 S. Hanson St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolism</i> DUE TO <i>Cerebral Embolism</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Cerebral Embolism</i> DUE TO (c) <i>Cerebral Embolism</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1959</i> to <i>30 Sept 1961</i> , that (I) (we) last saw the deceased alive on <i>30 Sept 1961</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above			
22a. SIGNATURE <i>A. H. H. H. H.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Maunce E. Newman &amp; Son</i>		24b. ADDRESS <i>Easton Md.</i>	
25a. REC'D BY REGISTRAR DATE <i>OCT 5 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4: may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

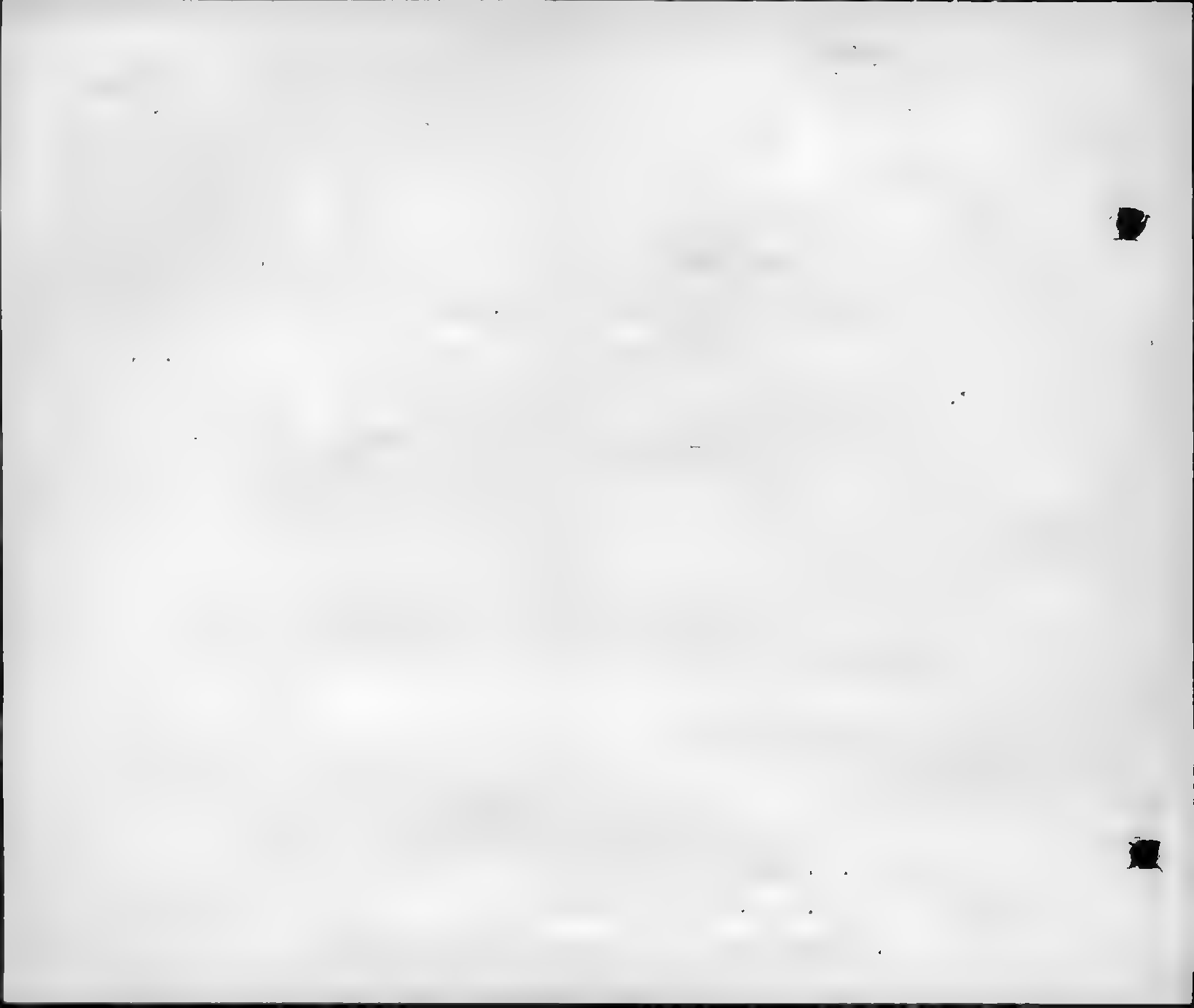
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10701

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b>				c. LENGTH OF STAY IN lb <b>14 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>"The Strand"</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b>			
f. STREET ADDRESS <b>"The Strand"</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>PASSANO</b> Last				4. DATE OF DEATH Month <b>Sept.</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 1, 1876</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		10. UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>10</b> Min		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Life Insurance</b>			
13. FATHER'S NAME <b>J. Ferdinand Passano</b>				14. MOTHER'S MAIDEN NAME <b>Ann Baldwin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-01-8928</b>			
17. INFORMANT <b>L. Baldwin Passano</b>				Address <b>The First P.A. Co Phila. 1, PA</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Angerona left leg</b> DUE TO (b) <b>arteriosclerosis, generalized</b> DUE TO (c) <b>lying cause last.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>10 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1935</b> to <b>9/13/1961</b> , that (I) (we) last saw the deceased alive on <b>9/12/1961</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. P. Evans Cox</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. P. Evans Cox</b>				22d. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>				ADDRESS <b>Easton, Maryland</b>			
25a. REC'D BY REGISTRAR <b>SEP 18 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frame</b>			





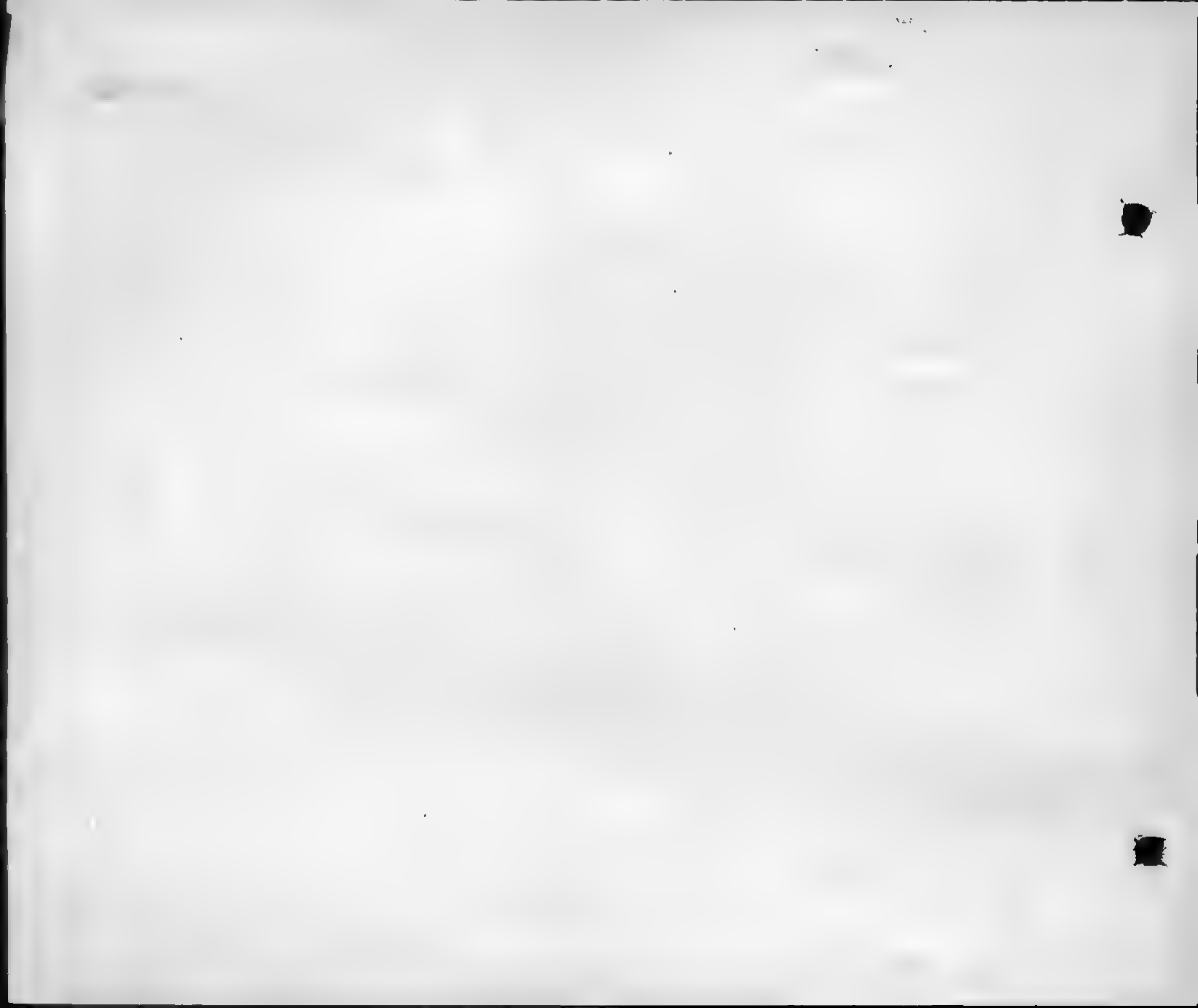
may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10709

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residential before admission) b. COUNTY <u>Talbot</u> MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>C</u> Last <u>Robbins</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1882</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Robbins</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Robbins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Arteriolar Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatectomy for Benign Prostatic Hypertrophy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 58</u> , to <u>9/16</u> 1961, that (I) (we) last saw the deceased alive on <u>9/16</u> 1961, and that death occurred on <u>9/17</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Shepard Krech Jr</u>		22b. DATE SIGNED <u>9/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Shepard Krech Jr</u>		22d. ADDRESS <u>EASTON Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		23b. DATE THEREOF <u>9/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Warner Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice R. Newmanson</u>		25. REC'D BY REGISTRAR DATE <u>SEP 20 '61</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>C. E. S. Kane</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10711

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>12 da</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>1</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>HARRY</i> Middle <i>Thomas</i> Last <i>Thomas</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>16</i> Year <i>1961</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21, 1874</i>	
9. AGE (In years last birthday) <i>87</i> yrs.		10. FUND 1 YEAR IF UNDER 24 HRS. Months <i>8</i> Days <i>7</i> Hours <i>15</i> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Raised Bro. Poultry</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carman</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William H. Thomas</i>		14. MOTHER'S MARRIEN NAME <i>Lillian Seymour</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>705-10-3052</i>		
17. INFORMANT <i>Miss Paul Elms</i>		Address <i>Easton Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive heart failure</i> DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Unknown</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <i>&gt;12 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/14/1961</i> to <i>9/16/1961</i> , that (I) (we) last saw the deceased alive on <i>9/14/1961</i> , and that death occurred at <i>3:35 PM</i> , from the causes and on the date stated above.				
22a. SIGNATURE <i>Robert W. Trever</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> SIGNED <i>9/18/61</i>		
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		M.D. <i>M.D.</i> 22d. ADDRESS <i>Easton, Maryland</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>Sept. 19, 1961</i>		
23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Easton Maryland</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice A. Neerink</i>		ADDRESS <i>505 Easton, Md.</i>		
25a. REC'D BY REGISTRAR DATE <i>SEP 20 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10705

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural-Cordova</b>				c. LENGTH OF STAY IN 1b <b>48 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Rebecca</b> Last <b>Voshell</b>				4. DATE OF DEATH Month <b>September</b> Day <b>21</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1867</b>	9. AGE (In years last birthday) <b>94</b> yrs.	IF UNDER 1 YEAR Months <b>94</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Hopkins</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Cooper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Miss Mary A. Voshell, Cordova, RD, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO <b>450</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1960</b> to <b>Sept. 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>9-20</b> 19 <b>61</b> , and that death occurred at <b>home</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dawson O. George</b>				22b. DATE SIGNED <b>SEP 26 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dawson O. George, M.D.</b>				22d. ADDRESS <b>Denton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Frampton Carroll, Easton, Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 26 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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